Opportunities for Improved Health Service Delivery
Healthcare Commission Ideas for Governor Freudenthal
June 29, 2005

Review Impact of Surgery Centers and Specialty Hospitals

1) What is the problem?

- **a)** Wyoming's community hospitals are impacted by an increasing number of Ambulatory Surgery Centers (ASCs) and specialty hospitals.
- **b)** As sole community providers, Wyoming's community hospitals must treat/admit all who come to their doors.
- **c)** There is data indicating physician owned specialty hospitals and surgical centers tend to treat those who have insurance coverage and/or those patients with the lowest clinical risk, leaving the community hospitals to treat the uninsured and the highest clinical risk patients.
- **d)** While supporters of ASCs and specialty hospitals argue that they foster competition, lower costs and increased quality, these claims are largely unsupported.[1]
- **e)** Several ASCs are already licensed in Casper (4), Cheyenne (5), Cody (1), Gillette (2), Jackson (1), Lander (1), and Rock Springs (1).[2] A specialty hospital is licensed in Laramie.
- **f)** New physician-owned specialty hospitals/surgical centers are being contemplated or "rumored" in Casper, Sheridan and Riverton and several other locations around the state.
- **g)** Physicians are motivated to build their own facilities, at least in part, in order to gain control over their schedule (not have surgeries bumped to accommodate emergencies), and to be able to gain more control over the quality/personality of the staff assisting them. Another motivating factor is the ability to capture facility fees that would otherwise accrue to the hospital.
- **h)** At the federal level, the Medicare Modernization Act of 2003 put a moratorium on the construction of new specialty hospitals until June 8, 2005. The Medicare Payment Advisory Commission (MedPAC) advised extending that moratorium until January 1, 2007, but that did not happen.
- **i)** CMS Administrator Mark McClellan has indicated CMS will not review any new applications until the end of the year, while CMS considers other MedPAC recommendations to adjust payment rules and re-examine the definition of a "hospital."

2) Describe your ideas.

- **a)** Evaluate the impact of existing ASCs and specialty hospitals on Wyoming's community hospitals. The review must include a complete description of the various ownership scenarios in each facility studied and it should include an examination of the contentions that:
  - **i)** Physician-owned ASCs differ from physician-owned specialty hospitals in their impact on the community.
  - **ii)** Physician-owned ASCs and specialty hospitals are good for a community because they increase competition and increase the quality of care.
  - **iii)** Physician-owned ASCs and specialty hospitals provide a cost-effective and more service-oriented alternative to employers paying for health care and their employees scheduling health care services.
  - **iv)** Physician-owners of ASCs or specialty hospitals direct patients that are lower-risk – financially and clinically – to their facilities while admitting higher risk patients to the community hospitals.
  - **v)** Physician-owned ASCs and specialty hospitals focus on procedures with higher reimbursement levels relative to cost – those with highest net revenue (Cardiothoracic Surgery, Neurosurgery, Orthopedics, General Surgery).
  - **vi)** Physician-owned ASCs and specialty hospitals pull critical staff from community hospitals forcing community hospitals to pay more for staff resources or limit services.
  - **vii)** Physician-owned ASCs and specialty hospitals impact the financial stability of general acute-care community hospitals reducing their ability to subsidize under-reimbursed and unreimbursed community health services (emergency services, endocrinology, health education).

viii) Physician-owned ASCs and specialty hospitals result in increased utilization of services and increased costs to the healthcare system.

b) The State of Wyoming should work with CMS and MedPAC to make sure rural healthcare needs are considered when those entities make their recommendations and/or regulations.

3) Who are your partners?

a) Department of Health who is responsible for licensing healthcare facilities in the state.
b) CMS and MedPAC are continuing to study the issue and will make recommendations.
c) Full-service, acute-care, community hospitals treat everyone in the community and potentially suffer financially when paying patients are directed to other care centers.
d) The Wyoming Hospital Association represents the full-service acute-care community hospitals and the Critical Access Hospitals.
e) Individual Wyoming hospitals affected by the new facilities.
f) Blue Cross/Blue Shield, Great West, WIN Health Partners and other payers.
g) Wyoming's business community, which pays the premiums for commercial coverage.
h) County governments supporting the community hospitals and relying on them to provide care to special populations.
i) The Wyoming Medical Society (WMS membership is divided on this issue).
j) Various medical sub-specialty organizations.

4) Please provide supporting evidence and data for the proposal.

a) Specialty hospitals have been part of the U.S. health care system since Medicare's inception. Hospitals that specialize in care for children, women, eyes, and other specific areas have long been part of the medical landscape. What has raised questions and concerns in recent years is the rapid growth of small, physician-owned hospitals specializing in cardiac care, orthopedics, and surgery—services thought to be highly profitable. Advances in medical technology, pressure on physician incomes, dissatisfaction with the responsiveness of community hospitals, distortions in the payment system, and conversion of ambulatory surgical centers to surgical hospitals have been cited as contributing to specialty hospital development.[3]

b) MedPAC analyzed hospitals' Medicare cost reports and inpatient claims from 2002 (the most recent available) and found that:
- **i)** Physician-owned specialty hospitals thus far do not have lower costs for Medicare patients than community hospitals, although their patients have shorter lengths of stay.
- **ii)** Physician-owned specialty hospitals treat generally less severe cases (and hence expect to be relatively more profitable than average) and concentrate on particular diagnosis-related groups (DRGs), some of which are relatively more profitable.
- **iii)** Physician-owned specialty hospitals tend to have lower shares of Medicaid patients than community hospitals.
- **iv)** The financial impact on community hospitals in the markets in which physician-owned specialty hospitals are located has been limited, to date. Community hospitals competing with specialty hospitals have demonstrated financial performance comparable to other community hospitals.
- **v)** Many of the differences in profitability across and within DRGs that create financial incentives for patient selection can be reduced by improving Medicare's inpatient prospective payment system for acute care hospitals.
- **vi)** Physicians may establish physician-owned specialty hospitals to gain greater control over how the hospital is run, to increase their productivity, and to provide greater satisfaction for themselves and their patients. They may also be motivated by the financial rewards.[4]

c) A case study of 4 sites - the Black Hills region in South Dakota, Oklahoma City, Wichita Kansas, and Lincoln Nebraska - found that when specialty hospitals opened:
- **i)** Facilities, capacity and numbers of physicians and staff increased in selected well-reimbursed services
- **ii)** The financial health of full-service hospitals declined creating cutbacks in behavioral health, trauma, outpatient clinics, health education/wellness and other "subsidized" services
- **iii)** Procedures per capita increased, raising concerns about over-utilization

iv) Capacity, including specialized equipment, was duplicated
v) Costs of maintaining standby/emergency capacity at community hospitals increased as elective cases were directed elsewhere
vi) Wage rates were raised by competition for scarce staff
vii) In 2 of 4 sites, trauma and emergency services were placed at risk because physician-owners reduced or eliminated their emergency call obligations, creating a severe shortage of call coverage
viii) Physician owners were able to direct lower-risk patients to the hospitals they owned
ix) Operating margins at physician owned specialty hospitals were up to 10 times higher than the national average for all community hospitals
x) Profits per physician-investor were as much as $700,000 per year[5]

d) A sincere effort to find data to support the case that competition from physician-owned facilities improves quality and/or reduces cost has met with limited success.[6] Many ASC management company web sites (National Surgical Hospitals, MedCath) explain the benefits for physician-owners, but do not provide information regarding benefits to the community at large. We will continue to search for data supporting the arguments favoring physician-owned facilities.

i) A MedCath-funded study by the Lewin Group found that:
(1) As a group, MedCath heart hospitals have a 20.3% higher case mix severity for cardiac patients than the peer community hospitals.
(2) After adjusting for risk of mortality, MedCath heart hospitals on average exhibited a 17.1% lower in-hospital mortality rate for Medicare cardiac cases compared to the peer community hospitals. A year ago, that figure was 11.8%.
(3) MedCath heart hospitals also had shorter average lengths of stay (ALOS) for cardiac cases (3.84 days) than the peer community hospitals (4.81 days) after adjusting for severity. A year ago, MedCath's ALOS was 4.12 days, compared with 5.06 days for peer community hospitals.[7]

ii) American Medical Association President John Nelson, M.D., speaking at the Wyoming Medical Society annual meeting at Jackson Lake Lodge on June 10, 2005, indicated some studies show physician-owned facilities do deliver higher quality care, but acknowledged the issue of payer mix associated with these entities.

5) Funding/Staffing needs.

a) $150,000 to $300,000 to hire a consulting firm to do the study.

6) Who is better off and how could you measure the improvement?

a) The State of Wyoming will be in a better position to understand the effect of physician-owned facilities on healthcare costs, quality and access.

7) Could this proposal be included in the Children and Families Initiative?

a) Indirectly. A better understanding of issues in the delivery healthcare will enable the state to do a better job of "steering" the system – driving out unnecessary costs and thus improving access.

8) Potential drawbacks and political considerations.

a) Physician owners of existing ASCs and specialty hospitals will resist the examination and attempt to refute any negative findings.
b) Physicians contemplating construction of new ASCs and specialty hospitals will resist the delay.
c) Community hospitals that co-own ASCs or specialty hospitals along with community physicians may need to be examined separately.

9) Alternative possibilities.

a) Wait and see what happens at the federal level before taking any local action.
b) Encourage "gain sharing" among community hospitals and community physicians to encourage the parties to work together to find efficiencies in daily operations and to increase physician satisfaction.

c) Require all ASCs and specialty hospitals to provide emergency services 24/7 and to comply with all emergency service provider laws and regulations.

d) Require all ASCs and specialty hospitals to serve a patient mix that statistically mirrors the patient mix in the community hospital in terms of payment method (commercial, Medicare, Medicaid, charity, etc.) and clinical acuity (APR-DRG mix).

e) Forbid physicians from admitting patients to a hospital in which they have an ownership stake (no self-referral). (For existing facilities, this would have to be phased in.)

10) How does this recommendation relate to other recommendations?

a) This issue could be studied within the context of a State Health Work Force and Delivery System Plan.

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[1] Casalino, Lawrence P., et al. "Focused Factories? Physician-Owned Specialty Facilities." *Health Affairs* November/December 2003

[2] Office of Health Facilities, Wyoming Department of Health, printed Sept. 2004

[3] MedPAC, Report to Congress, Physician Owned Specialty Hospitals, March 2005

[4] Ibid – page vii

[5] The Impact of Physician-owned Limited-service Hospitals: A Summary of Four Case Studies Prepared for: American Hospital Association, Colorado Health and Hospital Association, Kansas Hospital Association, Nebraska Hospital Association, South Dakota Association of Healthcare Organizations, by McManis Consulting February 16, 2005

[6] Cimassi, Robert James, The Attack on Niche Providers, presented to the American Association of Ambulatory Surgery Centers, March 11, 2005

[7] Dobson, Al, Ph.D. "A Comparative Study of Patient Severity, Quality of Care and Community Impact at MedCath Heart Hospitals." http://www.medcath.com/corp/content/Lewin-executive-summary-5-13-03.pdf May, 2003